COMMENTS

DEALING WITH A DEPRESSED WORKFORCE: ARE AMERICAN EMPLOYERS DOING ENOUGH TO SUPPORT THE MENTAL HEALTH CHALLENGES AFFECTING TODAY'S EMPLOYEES?

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I. INTRODUCTION

Americans today are faced with numerous mental health challenges. Some of the most common illnesses include: psychotic disorders, anxiety disorders, mood disorders, addiction disorders, eating disorders, personality disorders and impulse control disorders.[1] Depending on the type of

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1. *See* WebMD Health, *Mental Health: Types of Mental Disorders*, http://my.webmd.com/content/article/60/67134.htm?z=2950_00000_0000_rl_03 (last visited Oct. 29, 2006) (describing the symptoms of each type of disorder). For example, "[p]eople with anxiety disorders respond to certain objects or situations with fear and dread, as well as with physical signs of anxiety or nervousness, such as a rapid heartbeat and sweating." *Id.* People who suffer from an impulse control disorder can become so involved in their addictive

mental illness, the associated symptoms will vary and may be mild or severe.[2] Often mental illness begins with discrete symptoms that, if left untreated, manifest into a larger mental health disorder. For example, one health report shows that it is likely that an episode of mild or minor depression will escalate into major depression within fifteen years.[3] Because of high turnover and lack of employee loyalty, employers ignore such mental health issues. That may be true, but on the other hand, the employer may inherit the depressed employee from another company. The actual costs attributable to mental illness are $23 billion each year, but when you add the indirect costs, such as loss of productivity and absenteeism, the number reaches a staggering $249 billion annually.[4]

Mental illness exacts a heavy toll upon health and productivity in the United States and the world.[5] The effects have been hugely underestimated; in fact, mental illness ranked second only to cardiovascular disease as a burdening disease in established economies such as the United States.[6] The data indicates that mental health challenges exist and affect a significant portion of the American workforce. In light of that reality, this comment will focus on what American employers are doing or should be doing to recognize and deal with an employee population afflicted by mental illness.

Part II of this comment will focus on the legislative tools commonly used to protect employees dealing with mental disabilities. The Americans with Disabilities Act (ADA) mandates that employers shall not discriminate against an employee because of a disability.[7] As defined by the ADA, a disability is broad enough to include a physical or mental impair-

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activity (gambling, stealing, etc.) that they begin to ignore their relationships or responsibilities. *Id.* These types of disorders are considered to be common in today's society. *Id.*

2. WebMD Health, *Mental Health: Mental Health Basics*, http://my.webmd.com/content/article/60/67163.htm (last visited Oct. 29, 2006).

3. Miranda Hitti, *Nipping Depression in the Bud*, WEBMD HEALTH, Aug. 19, 2005, http://my.webmd.com/content/article/110/109632.htm.

4. JAMES G. FRIERSON, EMPLOYER'S GUIDE TO THE AMERICANS WITH DISABILITIES ACT 250–51 (2d ed. 1999).

5. U.S. DEP'T OF HEALTH AND HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 226 (1999), *available at* http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c1.pdf (basing its data on the Global Burden of Disease Study by the World Health Organization, the World Bank, and Harvard University).

6. *Id.* Data developed from the Global Burden of Disease Study also indicates that major depression ranked second in relation to the magnitude of the burden that diseases have on market economies. *Id.* Other mental illnesses, such as bipolar disorder, post-traumatic stress disorder, and obsessive compulsive disorder have also contributed to the burdens on established market economies. *Id.*

7. *See* Americans with Disabilities Act, 42 U.S.C. § 12112 (2005) (stating that "[n]o covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, ad-

ment.[8] Despite the ADA's coverage of mental disorders, only two percent of employment discrimination cases filed in federal court in 2003 under the ADA were won by plaintiffs.[9] With such an uphill battle to fight, employees who have suffered discrimination due to a mental health illness are not likely to pursue a claim. In addition to the ADA, American employees also have rights under the Family Medical Leave Act (FMLA) which allows an employee to take job-protected leave for the birth of a child, to care for a family member, or due to a serious health condition.[10]

Part III of this comment will address the changing demographic of the American workforce and the mental health issues prevalent among employees today. Although many mental health disorders can be treated, treatment is often avoided or postponed because of the stigma attached to the disease.[11] Employers can play an instrumental role in minimizing the number of employees suffering the effects of mental illness by developing a plan that supports treatment and makes mental health services readily available to their employees.

Part IV will focus on the inequities between general medical coverage and mental health services available through health care providers. The Paul Wellstone Mental Health Equitable Treatment Act seeks to resolve this issue and provide parity for mental health treatment.[12] By refusing to treat mental health disorders at the same benefit level as general medical disorders, health insurance providers are discriminating against those with mental health diseases. These employees are suffering from legally recognized disabilities yet are not receiving adequate and equal treatment from health care providers.

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vancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment").

8. *See id.* at § 12102 (defining disability as "a physical or mental impairment that substantially limits one or more of the major life activities of such individual").

9. *See* Michael D. Reisman, Note, *Traveling "To the Farthest Reaches of the ADA," or Taking Aim at Employment Discrimination on the Basis of Perceived Disability?*, 26 CARDOZO L. REV. 2121, 2125 (2005) (explaining that in many cases, the defendant did not prevail on the merits but that the employee failed to prove a qualified disability under the statute).

10. *See* Family Medical Leave Act, 29 U.S.C. § 2612 (2005) (granting eligible employees an entitlement of "a total of 12 workweeks of leave during any 12-month period").

11. *See* HEALTH AND HUMAN SERVS., *supra* note 5 (listing other barriers in addition to stigma such as cost and the under-recognition of mental health disorders).

12. *See* Paul Wellstone Mental Health Equitable Treatment Act, H.R. 1402, 109th Cong. (2005) (enacted) (describing its purpose as a bill "to provide for equal coverage of mental health benefits with respect to health insurance coverage unless comparable limitations are imposed on medical and surgical benefits").

Finally, Part V will propose that American employers have the ability to make a significant impact on the public health issue that is mental illness. Employers should address mental health issues in the workplace. The approach must be geared toward maintenance, treatment and prevention. Reactive solutions as provided by legislation such as the ADA and FMLA provide some protection, but employers must adopt a proactive approach to assist the mentally disabled workforce.

II. LEGAL HISTORY

Construction of the ADA in 1990 was spawned by congressional findings that forty-three million Americans suffer from a physical or mental disability.[13] As a result, the ADA fashioned the general rule that, "[n]o covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment."[14] The Act further defines disability as a physical or mental impairment substantially limiting one or more of life's major activities, a past record of such impairment, or "being regarded as having such an impairment."[15] Hence, the ADA prohibits discrimination based on a health related disability that substantially limits an individual's major life activity.

Noticeably present in the definition of disability is the inclusion of mental impairment.[16] Mental illness is one of the most difficult issues faced by employers in compliance with the ADA.[17] In order to comply with the mandates of the ADA, employers must understand who is protected under the law, make a distinction between the myths and truths surrounding mental illness, and gain an elementary understanding of the major forms of mental illness.[18] Individuals suffering from mental health disorders are stigmatized, degraded and often considered dangerous.[19]

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13. *See* Americans with Disabilities Act, 42 U.S.C. § 12101 (2005) (stating that "some 43,000,000 Americans have one or more physical or mental disabilities, and this number is increasing as the population as a whole is growing older").

14. *Id.* at § 12112.

15. *See id.* at § 12102 (stating that "[t]he term 'disability' means, with respect to an individual[,] (a) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (b) a record of such an impairment; or (c) being regarded as having such an impairment").

16. *See id.* (explaining that "disability means . . . . a physical or mental impairment").

17. FRIERSON, *supra* note 4, at 249.

18. *See id.* (stating that this will be important whether dealing with job applicants, employees with a current mental illness, or employees with a history of mental illness).

19. *See id.* (explaining why mental illness is such a difficult subject for employers).

At some point in their life, nearly half of all Americans will personally experience a mental disorder; many of these episodes will involve mild forms of depression for which many will not seek treatment.[20] Nonetheless, forms of mental illness such as depression must not be discounted. Individuals with minor depression are very likely to see the illness develop into major depression.[21] The good news is that depression is a very treatable disease.[22] The key to treatment is recognition of the existence of a mental illness and the assumption that treatment is available. Employers can assist in both of these areas by understanding mental illness, how it affects employees, and by offering health insurance coverage with benefits geared toward achieving mental health.

Successful interpersonal relationships, personal well-being, and a contribution to society or community are impossible without good mental health.[23] Without the benefit of mental health treatment, mentally ill employees will be negatively impacted on the job. When a mental disorder does emerge, it is not uncommon for the employee to encounter negative comments from fellow workers or an organized attempt to ostracize or terminate his or her employment.[24] This negative treatment must be replaced with proactive attempts to help the employee.

Public attitudes toward mental illness in the 1950s were compared to attitudes in the 1990s in a recent publication of the Surgeon General's Report on Mental Health.[25] The results show that while Americans have achieved a greater understanding of mental illness, the social stigma remains embedded in the U.S. population.[26] Insurance providers perpetuate this stigma because most benefit levels for mental health treatment

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20. *See id.* at 250 (citing a study out of the University of Michigan which also found that thirty percent of Americans had experienced a psychiatric disorder the previous year and that fourteen percent of Americans had suffered three or more serious instances of psychiatric disorders).

21. *See* Hitti, *supra* note 3 (citing a study that found "participants with minor depression were six times as likely to develop major depression").

22. *See* FRIERSON, *supra* note 4, at 253 (stating manic-depressive illness is very treatable). With proper medication such as lithium carbonate, the number and intensity of manic depressive episodes can be reduced by seventy percent for some patients and can completely eliminate manic episodes in other patients. *Id.* Also, the addition of other medications and psychotherapy can result in controlling manic and depressive phases in most individuals who are treated. *Id.*

23. *See* HEALTH AND HUMAN SERVS., *supra* note 5, at 4 (describing mental health as indispensable for such common relationships).

24. *See* Debele v. Sprint/United Mgmt. Co., 342 F.3d 1117, 1122 (10th Cir. 2003) (stating that the comments made by Doebele's co-workers about her mental health had circulated throughout the department and many questioned her mental stability).

25. *See* HEALTH AND HUMAN SERVS., *supra* note 5, at 7.

26. *See id.* (explaining that in the 1950s mental illness was viewed as a stigmatized condition for which there was an unscientific understanding as compared to the 1990s

are a fraction of the levels provided for standard medical care. Additionally, the ADA does not provide significant and meaningful protection to employees suffering from mental health disorders. As such, Representative Patrick Kennedy introduced a bill to combat this inequity. The Paul Wellstone Mental Health Equitable Treatment Act[27](Wellstone Act) seeks to fight the second-class status assigned to individuals with mental health or emotional disorders.[28] The primary goal of the proposed Act is to provide equal health care coverage for mental health benefits as compared to medical and surgical benefits.[29] Other legislation in step with this trend of enhancing and equalizing mental health treatment is the Veterans Mental Health Care Capacity Enhancement Act of 2005[30] and the Medicare Mental Health Copayment Equity Act of 2005.[31]

This companion legislation indicates that while Congress has created a relief system for employees who have suffered disability discrimination at the hands of an employer,[32] there are proactive steps that can be taken to prescribe rules for providing preventive, treatment-based options to employees who wish to address signs of compromised mental health. The Wellstone Act seeks to prohibit treatment limitations for mental health if such limitations are not even-handedly applied to medical and surgical benefits.[33] Additionally, the Medicare Mental Health Copayment Equity

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where Americans possessed a more scientific understating but still subjected mental illness to a social stigma).

27. Paul Wellstone Mental Health Equitable Treatment Act, H.R. 1402, 109th Cong. (2005) (enacted).

28. *See* AM. COUNSELING ASS'N, PARITY OF INSURANCE COVERAGE FOR MENTAL HEALTH TREATMENT, *available at* http://www.counseling.org/PublicPolicy/PositionPapers.aspx?AGuid=72f8b242-7ee7-446c-9cbf-bad609859690 (last visited Oct. 29, 2006) (referencing the stigmatization and discrimination suffered by those with mental health disorders).

29. *See* Paul Wellstone Mental Health Equitable Treatment Act, H.R. 1402, 109th Cong. (2005) (enacted) (detailing the Act and its potential impact on employee's suffering from mental health disorders). More specifically, the preamble to the Wellstone Act states that the bill is "[t]o provide for equal coverage of mental health benefits with respect to health insurance coverage unless comparable limitations are imposed on medical and surgical benefits." *Id.*

30. Veterans Mental Health Care Capacity Enhancement Act of 2005, S. 1177, 109th Cong. (2005) (enacted) (seeking to improve mental health services provided by the Department of Veterans Affairs (the VA) based on findings that mental health treatment at facilities operated by the VA is inadequate and inconsistent).

31. Medicare Mental Health Co-payment Equity Act of 2005, S. 1152, 109th Cong. (2005) (enacted) (seeking to gradually eliminate discriminatory co-payments for outpatient psychiatric services by stepping down the costs through year 2011).

32. *See generally* Americans with Disabilities Act, 42 U.S.C. § 12112 (2005) (warning employers that "no covered entity shall discriminate against a qualified individual with a disability").

33. Paul Wellstone Mental Health Equitable Treatment Act, H.R. 1402, 109th Cong. (2005) (enacted).

Act attempts to eliminate the discriminatory practice associated with outpatient psychiatric services which allows a disproportionately high co-payment for mental health services.[34]

Regardless of the level of mental health care coverage provided by an employer's health plan, an employee suffering from a mental illness must not rely solely on the ADA for protection. Naturally one would think that the ADA acts not only as a reactive measure to redress the legal wrongs imposed on the plaintiff-employee, but also serves as a deterrent for employers who might otherwise attempt some form of discrimination against the disabled. In theory, the ADA provides legal resources for employees facing discrimination due to mental illness.[35] However, in reality, employees who suffer from a mental health disability bear a heavy burden of proving the disability qualifies under the ADA.[36]

In order to successfully litigate a cause of action under the ADA involving discrimination based on a mental disability, the employee must take the assertive step of filing a claim with the Equal Employment Opportunity Commission (EEOC) or a fair employment practices agency of a particular state.[37] If the government agency declines to pursue the claim, the employee's only option is to retain an attorney and commence the difficult task of litigating a discrimination claim.[38] If the employee is severely impaired in relation to "interpersonal, cognitive, or communications skills," he or she is not likely to possess the confident and assertive nature necessary to individually pursue such a claim.[39] Hence, in effect the employee is left with no recourse at all.

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34. Medicaid Mental Health Co-payment Equity Act of 2005, S. 1152, 109th Cong. (2005) (enacted).

35. *See* Americans with Disabilities Act, 42 U.S.C.A. § 12101 (2005) (listing one of many findings of Congress regarding the need for comprehensive legislation to protect American's with disabilities).

36. *See generally* Johnson v. City of New York, 326 F. Supp. 2d 364, 368–69 (E.D.N.Y. 2004) (holding plaintiff's medical condition constituted impairment under the ADA but that plaintiff did not produce any evidence of an inability to perform a major life activity); *see also* Glidden v. County of Monroe, 950 F. Supp. 73, 76 (W.D.N.Y. 1997) (explaining that despite a previous nervous breakdown, plaintiff did not suffer from a mental impairment substantially limiting her major life activities); *see also* Starks-Umoja v. Fed. Express Corp., 341 F. Supp. 2d 979, 992 (W.D. Tenn. 2003) (stating that plaintiff did not produce evidence to show bipolar disorder substantially limited a major life activity).

37. *See* RICHARD J. BONNIE & JOHN MONAHAN, MENTAL DISORDER, WORK DISABILITY, AND THE LAW 205 (University of Chicago Press 1997) (explaining that the ADA is largely self-administering and enforcement depends largely on the employers conscience to make fair employment decisions). If such decisions are unfair, an employee with a psychiatric disability will be at a disadvantage. *Id.*

38. *See id.* (referring to the typical case where the EEOC or state agency declines to prosecute a discrimination charge).

39. *See id.*

Unfortunately, because of the way the ADA functions, it is possible that an employer will knowingly act in a manner inconsistent with the mandates of the ADA hoping that if an aggrieved employee actually pursues a claim, the employer would prevail due to the difficult burden of proof placed upon the plaintiff in proving disability discrimination. Employers are fully aware of the severe difficulties facing plaintiffs in ADA claims, and they often prevail, not because their defense is meritorious, but because the plaintiff fails to meet the substantial burden of proof under the statute.[40] Despite the seemingly broad definition of disability under the ADA,[41] its application to real life situations is a challenge and often results in an employee's failure to show a qualified disability under the ADA.[42] To establish a prima facie case of disability discrimination under the ADA, a plaintiff must show (1) the existence of a disability within the meaning of the ADA; (2) that the employee is qualified for the position; and (3) that the employee was discriminated against because of the disability.[43] This is a huge mountain for the plaintiff-employee to climb.

Additionally, the Courts will consider any mitigating circumstances which act to erase the employee's disability.[44] In *Sutton v. United Airlines Inc.*,[45] the Court stated:

> A person whose physical or mental impairment is corrected by medication or other measures does not have an impairment that presently "substantially limits" a major life activity. To be sure, a person whose physical or mental impairment is corrected by mitigating measures still has an impairment, but if the impairment is corrected it does not "substantially limit" a major life activity.[46]

This is significant because if an employee is fortunate enough to have comprehensive health care coverage which provides meaningful treat-

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40. Reisman, *supra* note 9.

41. *See* Americans with Disabilities Act, 42 U.S.C. § 12102 (2005) (defining disability as "a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment").

42. Reisman, *supra* note 9.

43. Poindexter v. Atchison, Topeka & Santa Fe Ry. Co., 168 F.3d 1228, 1230 (10th Cir. 1999).

44. *See* Sutton v. United Air Lines Inc., 527 U.S. 471, 482 (1999) (explaining that medication or other measures which do not leave the employee presently disabled must be considered when determining whether the employee qualifies under the ADA).

45. *See id.* (summarizing the Court's opinion that the effect of any mitigating measures must bear on the determination of "substantial limitation").

46. *See id.* at 482–83 (declaring that the court comes to this conclusion by looking at the Act as a whole).

ment options for mental illness, such treatment acts as a mitigating measure and may prevent an ADA claim from being successfully litigated.

Employees are also afforded rights and protection under the Family Medical Leave Act.[47] The FMLA provides an employee twelve workweeks of job-protected "leave during any twelve-month period" for (1) childbirth in order to care for the newborn; (2) placement of a child for adoption or foster care; (3) care for a family member with a serious health condition; and (4) any serious health condition making "the employee unable to perform the functions of the position[.]"[48] A serious health condition is defined by the act as an "illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, or residential medical care facility; or continuing treatment by a health care provider."[49] If the employee qualifies for a leave of absence protected under the FMLA, the employer must notify the employee that the leave will count toward the twelve weeks allotted by the Act.[50] Upon notification, the clock on the employee's twelve week allotment begins ticking.[51] In the event the reason for taking FMLA requires an absence beyond twelve weeks, the employee is no longer protected.[52]

To qualify for coverage under the ADA, or FMLA, the worker must be employed by an organization that is subject to these federal mandates. The ADA defines a covered entity as an "employer, employment agency,

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47. *See* Family Medical Leave Act, 29 U.S.C. § 2611 (2005) (defining eligible employee as "an employee who has been employed for at least 12 months by the employer with respect to whom leave is requested under section 2612 of this title; and for at least 1,250 hours of service with such employer during the previous 12-month period").

48. *See id.* at § 2612(a)(1). The Act states:

> an eligible employee shall be entitled to a total of 12 workweeks of leave during any 12-month period for one or more of the following: (A) Because of the birth of a son or daughter of the employee and in order to care for such son or daughter; (B) Because of the placement of a son or daughter with the employee for adoption or foster care; (C) In order to care for the spouse, or a son, daughter, or parent, of the employee, if such spouse, son, daughter, or parent has a serious health condition; or (D) Because of a serious health condition that makes the employee unable to perform the functions of the position of such employee. *Id.*

49. *See id.* at § 2611(11) (stating that "[t]he term 'serious health condition' means an illness, injury, impairment, or physical or mental condition that involves (A) inpatient care in a hospital, hospice, or residential medical care facility; or (B) continuing treatment by a health care provider").

50. FRIERSON, *supra* note 4, at 312.

51. *Id.* at 312 (stating that without such notice, the employee's leave will not count against the twelve-week allotment).

52. *See generally* 29 U.S.C. § 2612 (2000) (limiting the benefit by stating that "an eligible employee shall be entitled to a total of 12 workweeks of leave").

labor organization, or joint labor-management committee."[53] The ADA further defines an "employer" as an entity that has fifteen or more employees which worked twenty or more calendar weeks in the prior year.[54] "Employer" as defined by the FMLA is one which employs fifty or more employees for at least twenty workweeks in the prior year.[55] If these requirements are not met and an employer is not covered under either of these Acts, the legal recourse provided through this legislation will not be available to the employee.

Despite legislation such as the ADA and FMLA, employers, not legislators, are in the best position to make a positive impact by providing meaningful health care benefits. This means that employers must move beyond the status quo and support initiatives that require equalization of health care for treatment of mental illness. Employees today have to deal with significant work obligations and family responsibilities. In turn, it is the responsibility of the employer to understand the composition of its workforce and the stresses and emotional challenges facing it.

III. Mental Illness in the American Workforce and its Impact on Employers

The employees of the American workforce can be categorized by position titles and physical characteristics. But these are not the only categories. Members of the sandwich generation,[56] veterans, and individuals coping with addiction are some examples of the additional classifications of employees in today's workforce. It is imperative that employers understand these classification subsets within their working population so they can better provide benefits and employee services. By offering benefits that fit the specific needs of the workforce, employers enhance the employee's chance of successfully dealing with a mental health challenge.

Because of the many hurdles facing the workforce, it is in the employer's best interest to help employees face these challenges. Those af-

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53. *See* Americans with Disabilities Act, 42 U.S.C. § 12111 (2005) (stating that "[t]he term 'covered entity' means an employer, employment agency, labor organization, or joint labor-management committee").

54. *See id.* (explaining that the term employer "means a person engaged in an industry affecting commerce who has 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year").

55. *See* Family Medical Leave Act, 29 U.S.C. § 2611(4)(A)(i) (2005) (stating that the term employer "means any person engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year").

56. Marty R. Seaward, *The Sandwich Generation Copes with Elder Care*, BENEFITS QUARTERLY, Second Quarter 1999, at 41 (defining sandwich generation as the group of individuals caring for their own children and elderly parents).

fected by mental health issues do not live in a vacuum. Consider the fact that more than forty-four million Americans provide care for another adult, and of these caregivers, nearly six out of ten worked while providing care.[57] It is therefore undeniable that workers face responsibilities and difficulties beyond those encountered at work. In fact, caregivers often experience a very high rate of depression and put their own health on hold to provide care for a loved one.[58]

American workers also confront problems with drug and alcohol abuse. Moreover, almost seventy-five percent of adult drug users and nearly eighty percent of adult heavy drinkers are employed either full time or part time.[59] In 2004, more than twenty-two million people reported dependence on or abuse of alcohol or illicit drugs.[60] Perhaps even more disturbing is the fact that of those who classified themselves as needing treatment, thirty-four percent cited insurance barriers or cost as a reason for not seeking treatment.[61] One reason listed for not seeking treatment was the lack of coverage for addiction treatment under traditional health care plans.[62]

Those with substance abuse issues often face the challenge of additional mental health issues. Moreover, half of the people dealing with serious mental illness also develop drug or alcohol abuse problems.[63] The resulting dual diagnosis makes substance abuse treatment a critical element in an individual's treatment for a mental disorder. Likewise, treatment for a mental disorder is equally important for the recovery of a

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57. AARP, *Caregiving Is a Second Job for Many*, http://www.aarp.org/states/oh/oh-news/a2004-04-21-oh-caregiving.html (last visited Oct. 29, 2006).

58. Suzanne Mintz, *The Depressed Caregiver*, WEBMD HEALTH, http://www.webmd.com/content/pages/5/4041_161.htm (last visited Oct. 29, 2006).

59. Katherine A. Durso, *Alcohol and Other Substance Abuses: Prevalence, Cost and Impact on Productivity*, EMP. BENEFIT NEWS, Sept. 1, 2004 (according to a 2002 National Survey on Drug Use and Health from the U.S. Substance Abuse and Mental Health Service Administration).

60. DEP'T OF HEALTH AND HUMAN SERVS., SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2004 NATIONAL SURVEY ON DRUG USE AND HEALTH: DETAILED TABLES, TABLE 5.25A, http://www.oas.samhsa.gov/NSDUH/2k4nsduh/2k4tabs/Sect5peTabs25to37.pdf (last visited Oct. 29, 2006).

61. *See* DEP'T OF HEALTH AND HUMAN SERV., SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2004 NATIONAL SURVEY ON DRUG USE AND HEALTH: DETAILED TABLES, TABLE 5.98A, http://www.oas.samhsa.gov/NSDUH/2k4nsduh/2k4tabs/Sect5peTabs98to99.pdf (last visited Oct. 29, 2006) (referring to 391,000 people who cited cost or insurance as a barrier out of 1,135,000 total respondents).

62. *See id.* (indicating that health care coverage is incomplete for those individuals who require treatment for alcohol abuse).

63. *See* HEALTH AND HUMAN SERVS., *supra* note 5, at 288.

person with a substance addiction.[64] Recovery from one is dependent upon the other.

An important point to remember is that it is difficult for a person suffering from a mental illness to tell even his or her closest friends or family about the illness.[65] It is natural that individuals are reluctant to tell others about their condition because of the stigma associated with mental illness.[66] Although slight, the reporting of mental health issues in America is on the rise.[67] Adults who reported incidents of mental distress[68] "increased from 8.4% in 1993 to 10.1% in 2001."[69] Society continues to be bombarded by negative images of those who suffer from mental illness.[70] It is understandable how this negativity can cause trepidation among the mentally ill, especially since ignorance and insensitivity perpetuate the stigma.[71] Clearly, if a person suffering from a mental illness is afraid to tell a family member, revealing such information to a supervisor or colleague is even less likely. Therefore, it is necessary to remove the stigma attached to mental disorders in order to successfully treat and address mental illness.

The damaging effects of the stigma associated with mental illness can be reduced via confidentiality. Employers should be concerned about privacy implications related to discussing an employee's mental health. Supervisors and managers should also be familiar with the term "protected health information."[72] This term refers to "individually identifi-

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64. *See id.* (explaining that a dual diagnosis (also known as comorbidity) that treats each condition separately often proves ineffective).

65. Sarah Albert, *Coming Out About Mental Illness*, WEBMD HEALTH, http://my.webmd.com/content/article/98/104692.htm (last visited Oct. 29, 2006).

66. *See id.*

67. *See* Jennifer Warner, *Poor Mental Health on the Rise in the U.S.*, WEBMD HEALTH (Oct. 21, 2004), http://my.webmd.com/content/article/95/103448.htm (referring to an increasing number of Americans who report feeling stressed and depressed).

68. *See id.* (defining frequent mental distress as fourteen or more days during the last thirty days where the individual has experienced problems with stress, depression, and emotions).

69. *Id.* (referencing a Center for Disease Control (CDC) nationwide survey). CDC researchers found that a growing number of Americans are experiencing some form of depression which suggest that poor mental health is on the rise. *Id.* This suggests that there needs to be more efforts to encourage adults to seek treatment for their mental illnesses. *Id.*

70. NAT'L MENTAL HEALTH ASS'N, STIGMA WATCH, *available at* http://www.nmha.org/newsroom/stigma/index.cfm (last visited Oct. 26, 2006) (referring to depiction of individuals with mental health issues as "dangerous, violent and unpredictable").

71. Albert, *supra* note 65.

72. 45 C.F.R. § 160.103 (2004) (defining protected health information as "identifiable health information . . . that is: (i) transmitted by electronic media; (ii) maintained in electronic media; or (iii) transmitted or maintained in any other form or medium").

able health information"[73] and the Privacy Rule within the Health Insurance Portability and Accountability Act (HIPAA) requires a covered entity to protect private health information.[74] This rule was designed to protect employees.[75] Under HIPAA, employees retain the right to give consent for the use or disclosure of personal health information.[76]

While still honoring the employee's privacy rights, the employer can also encourage employees to utilize an Employee Assistance Program (EAP). Such programs are staffed with trained counselors who are skilled in screening for depression symptoms over the phone and can even provide short-term counseling until long-term treatment through a mental health professional can be arranged.[77] Early screening helps the employee understand the seriousness of his or her condition and starts the employee on the road to proper treatment.[78] An EAP is not designed to treat mental illness but acts as an excellent referral tool to steer the employee toward physicians and counselors capable of offering treatment for mental health problems.[79] In addition to the importance of offering a screening tool for employees who feel they suffer from depression or some type of mental illness, proper treatment is equally important. Primary care physicians are often involved in the initial contact with the patient but such physicians may not be trained to handle mental health problems such as depression.[80] One expert states that "50% to 60% of patients with depression receive their treatment from primary care physicians."[81] Many of these doctors simply are not equipped with the time or

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73. *Id.*

74. *See* Kelley M. Blassingame, *What You Need to Know About "HIPAA," But Didn't Know to Ask*, EMP. BENEFIT NEWS, May 1, 2003 (addressing the Privacy Rule's requirement that employers limit those who may access an employee's protected health information).

75. *See id.* (quoting Chris Lipski, director of HIPPA for Employers, who explains that HIPAA is "pro-employee law"). HIPPA requires employers, as sponsors of company health care plans, to institute certain safeguards to protect employees PHI in addition to honoring the numerous privacy rights guaranteed to employees under the privacy rule. *Id.*

76. *See id.* (granting employees the final say over who gets access to protected health information).

77. Carolyn Hirschman, *Education, Screening Defang Workplace Depression*, EMP. BENEFIT NEWS, Dec. 1, 2004 (stating that EAPs are useful in identifying mental health disorders in employees). Even companies without EAPs can provide employees with information regarding free community and internet-based screening tools. *Id.*

78. *See id.* (citing a University of Michigan survey finding that only eleven percent of managers overseeing employee benefits programs actually facilitate employee screening).

79. *See* Leah Carlson, *EAP Use Increasingly Centers Around Stress, Family Issues*, EMP. BENEFIT NEWS, Sept. 1, 2005 (stating that EAPs are not "mini-health clinic[s]" and are not "meant to treat mental illnesses").

80. Hirschman, *supra* note 77.

81. Craig Gunsauley, *Prozac Nation*, EMP. BENEFIT NEWS, Mar. 1, 2002 (quoting Lloyd Sederer, M.D., director of clinical studies for the American Psychiatric Association

skill necessary to detect or treat depression in their patients.[82] Thus, despite seeking medical care, many patients still may not receive effective treatment.[83] To effectively treat mental illness, employees need access to physicians who specialize in mental health.

Mental health problems will not cure themselves. Employers suffer productivity loss because employees who are depressed or suffer from anxiety problems are unproductive about two hours each day.[84] Assuming the employee works a traditional eight-hour workday, twenty-five percent of that day is wasted, and yet the employer continues to pay. To prevent such waste of money and resources, the employer must seek to understand the impact of mental illness on the workforce. This understanding will help the employer make employee-friendly choices that include access to adequate mental health treatment.

The employer's logical interest in self-preservation will cause it to pursue cost-effective business strategies. Such predictable concern for the financial health of the company makes it even more perplexing that employers are willing to forgo $44 billion each year in lost productivity.[85] Recent studies show that two of the most common mental health disorders, depression and anxiety disorders, comprise the largest costs among untreated, yet treatable, illnesses.[86] When depression and stress are combined, the employee reporting these symptoms costs his or her employer 147% more than a mentally healthy employee.[87] Notwithstanding the financial impact, many employers do not offer proper screening tools or adequate mental health care. Even if employers lack compassion for the

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(APA) in Washington, D.C.). Sederer's office is responsible for developing APA practice guidelines for use by practitioners in the treatment of patients with mental health disorders. *Id.*

82. *See id.* (reiterating that primary care physicians are not experts in treating depressive illnesses).

83. *See id.* (stating that prescription antidepressant drugs are often used incorrectly and that prescriptions are often not monitored appropriately for proper refills and continued therapy).

84. David J. Berube, *Strategies Help Manage Workplace Depression*, EMP. BENEFIT NEWS, Sept. 15, 2002 (citing a MEDSTAT Group study which found that workers suffering from anxiety or depression are unproductive approximately two hours per day). The study also found that individuals suffering from depression have "high rates of absenteeism and are more likely to abuse alcohol and drugs." *Id.*

85. *See* Alan M. Langlieb & Jeffrey P. Kahn, *ROI from Mental Health Care is More Than Anecdotal*, EMP. BENEFIT NEWS, Jan. 1, 2004 (citing a study in the Journal of American Medical Association stating that employees suffering from depressive illnesses "cost employers forty-four billion dollars per year in lost [productivity]").

86. *See id.* (explaining that those employees who do report depression are seventy percent more costly to employers).

87. *See id.* (stating that the cost to employers in lost productivity is magnified when depression and stress occur simultaneously).

plight of their mentally ill employees, surely the realization that billions of dollars are lost due to lagging productivity should persuade employers to take a more proactive approach in regards to their employees' mental health.

Despite the reality of lost productivity and its associated costs, mental health benefits are on a decline.[88] This is illustrated by the fact that addiction treatment, a common subset of mental health treatment, is often viewed as a luxury.[89] Costs associated with addiction treatment are substantial but studies show that, for example, outpatient detoxification may, in some instances, be more cost-effective than residential, in-patient treatment.[90] Cost-effectiveness studies demonstrate that recovery is promoted at partial or day-hospital treatment programs with a lower expense than costly inpatient care.[91] In fact, simple intervention by primary care physicians of patients suffering from alcoholism can reduce drinking by up to fourteen percent in men and thirty-one percent in women.[92] Despite this evidence, efforts to control costs are geared toward limiting coverage to inpatient programs, which actually works to increase costs.[93] As a result, these higher costs reduce the benefits available for treatment and ultimately harm the employees in need of assistance.[94]

In some instances, treatment at an inpatient facility is appropriate and covered by the health care provider. Yet in one startling case, treatment

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88. *See id.* (citing a study by the Society for Human Resource Management which estimates that seventy-six percent of employers offered mental health benefits in 2002, compared to eighty-four percent in 1998).

89. *See* James W. Langenbucher, *Socioeconomic Analysis of Addictions Treatment*, 111 *Pub. Health Rep.* 135, Mar. 1996 (referring to some policymakers' view that addiction treatment is ineffective as compared to other medical technology).

90. *See id.* (noting that various cost-effectiveness studies compare different forms of addiction treatment).

91. *See id.* (explaining that outpatient addiction treatment can cost as little as ten to twelve dollars per day).

92. *See* Richard Saltus, *Counseling Seen as Aid to Drinkers*, THE BOSTON GLOBE, Apr. 3, 1997, at A3 (describing a Wisconsin study by sixty-four primary-care physicians who assigned half the participants deemed "problem drinkers" to an intervention program that included a counseling session with the doctor, workbooks dealing with drinking, a "prescription" to reduce drinking and drinking journal cards).

93. Langenbucher, *supra* note 89 (citing a study stating that outpatient detoxification treatment for patients suffering from alcohol and narcotics addiction is "markedly more cost-effective for the 90% or so of patients without serious withdrawal histories than the more common round-the-clock inpatient observation").

94. *See id.* (stating that cost containment strategies that focus on inpatient care cause outpatient strategies to take a back seat although such strategies have been met with success).

at an inpatient facility was denied and the results were tragic.[95] In *Andrews-Clarke v. Travelers Insurance Company*, Clarke, the husband of an employee and beneficiary to an employer-sponsored health plan, was refused enrollment in a thirty day alcohol rehabilitation program.[96] Instead, Clarke was admitted to the hospital for five days where it was determined he had an alcohol dependency, alcohol withdrawal symptoms, and problems with his liver function.[97] Upon his release, Clarke soon resumed drinking and committed suicide within a few months.[98] Clarke's untimely death resulted in spite of the fact that he was a named beneficiary on his employee-wife's health insurance policy, and that doctors repeatedly recommended treatment which was covered by the insurance policy.[99] Despite this, the insurance company refused to authorize treatment, and Clarke's tragic and untimely death followed shortly thereafter.

Examples like the *Andrews-Clarke* case indicate that employers must hold their insurance providers and themselves to a higher standard. In Clarke's case, his condition was covered by the health insurance plan, but the provider elected to place cost reduction above effective treatment. In instances like these, employers must act as an advocate for their employees and monitor the practices of their health care provider.

Employers are likely to cite skyrocketing health care costs as a reason not to offer mental health benefits.[100] In the five years prior to 2003 mental health benefits were reduced from eighty-four to seventy-six percent.[101] The reality is that physical health care costs more when mental

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95. *See* Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 51 (D. Mass. 1997) (explaining that although Clarke was entitled to treatment per his health insurance policy, the treatment recommended by physician was denied).

96. *See id.* (stating that the utilization review provider responsible for pre-approving treatment per the terms of Clarke's health insurance plan, refused to approve a month-long inpatient alcohol rehabilitation program, opting instead to authorize a short five-day hospital stay).

97. *See id.* (stating that the insurance plan's denial of appropriate inpatient treatment resulted in a twenty-five day sobriety period, followed by ultimate relapse and suicide).

98. *See id.* at 51–52 (explaining the course of events from the point that thirty-day inpatient treatment was denied until Clarke's death, which included: a suicide attempt, commitment to a state-sponsored detoxification program at a correction facility (instead of admission to a private program to which Clarke was entitled, where, incidentally, Clarke was forcibly raped and sodomized), protective custody by the police after a night of heavy drinking, and admission to the hospital with a blood alcohol level of .380).

99. *See id.* at 52 (asserting that Clarke's early death was a needless tragedy).

100. *See* Kathryn Tyler, *Mind Matters: Reducing Mental Health Care Coverage Today May Cost You More Tomorrow*, 48 HR MAGAZINE No. 8 (2003), *available at* http://www.shrm.org/hrmagazine/articles/0803/0803tyler_benefits.asp (explaining the usual responses to increased health care costs).

101. *See id.* (citing the Society for Human Resource Management annual benefits survey).

health care is not offered as part of the benefit plan.[102] A mental health problem that manifests itself physically leaves a physician ordering a battery of costly tests because he or she is unable to diagnose the underlying problem.[103] "Being on the fence about providing mental health care benefits is penny-wise and pound-foolish. Look at the whole picture. You may save some money by decreasing coverage, but if disability claims skyrocket as a result, what are you saving?"[104] By linking health care data with disability data, employers will learn that absences due to disability and lost productivity are four times as costly as traditional health plan expenses.[105] For one particular manufacturer, employees absent because of short-term disability accounted for nearly $1 billion of the $1.24 billion in health-related costs.[106]

In the event the employer provides health care coverage with a mental health benefit, the next consideration is whether the employee has been adequately educated to make a decision about health care. Cost is also a major issue for the employee. This is illustrated by one study that found more than fourteen million people saw "one-quarter of their earnings eaten up by health care costs."[107] Decisions regarding health care are important and the employer must realize that "health care is not a one-size-fits-all proposition."[108] As such, employers must play a proactive role by surveying the workforce to determine what type of individuals are using the health insurance plan and in turn, educating employees as to the benefits provided. For example employers could provide "health care report cards" to employees.[109] There is more to the health care decision

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102. *See id.* (noting the eliminating mental health benefits can "result in reduced productivity or extended disability leave").

103. *See id.* (explaining that an individual will seek treatment for the physical symptoms of a mental illness because treatment for the mental illness is unavailable).

104. *Id.* (quoting Russ Newman, Ph.D. and executive director for professional practice for the American Psychological Association in Washington, D.C.). Untreated mental illness in employees may lead to physical ailments requiring treatment or resulting in reduced productivity or prolonged disability leave. *Id.*

105. *See* Craig Gunsauley, *Disability Absences Drive Total Health Costs*, EMP. BENEFIT NEWS, Apr. 15, 2001 (explaining that employers who use this short-sighted approach are missing the big picture).

106. *Id.* (citing a study conducted by Integrated Benefits Institute which examined healthcare costs for a Midwest manufacturer and found that lost productivity due to employees absent for short-term disability reasons represented about eighty percent of the total health care costs).

107. Karen Lee, *Balancing Cost and Quality in Picking a Health Plan*, EMP. BENEFIT NEWS, Nov. 1, 2004.

108. *See id.* (quoting The National Committee for Quality Assurance Spokesman encouraging employees to consider cost, network and quality in selecting health care plans).

109. *See id.* (indicating that health care report cards are available by state and also available at consumer websites such as www.healthchoices.org).

than cost, and employees should be encouraged to consider the important details of health plans such as specialist care, prescription drug coverage, mental health care, counseling, and services for drug and alcohol abuse.[110] Employers could further help employees by establishing a comprehensive benefits campaign rather than a one-time orientation program.[111] The campaign should target specific groups of employees and, in the long run, result in healthier, more informed employees.[112]

In addition to creating an informed workforce, the employer must also endeavor to supply health insurance that provides equal coverage for mental health care and medical and surgical benefits. No one expects the employer to play the role of doctor, but great strides can be made in dealing with mental illnesses by endeavoring to train supervisors to recognize symptoms of mental illness, encouraging employees to seek screening or referral through an EAP, and finally, and most importantly, by providing adequate and equitable mental health coverage.[113]

IV. THE DEFICIENCIES OF THE MENTAL HEALTH PARITY ACT AND OTHER PROTECTIONS PROVIDED TO EMPLOYEES SUFFERING FROM MENTAL ILLNESS

Americans will not receive mental health parity if they do not demand it from their employers. The health care industry in the United States has denied equal treatment for mental health benefits for so long because there has not been adequate demand for such services.[114] Lack of demand results from stigma and misinformation.[115] There is a perception in the United States that a person who is mentally ill is to blame for his or her condition.[116] The resulting stigma creates a resistance to treatment

110. *See id.* (encouraging employees to determine what is important to them when selecting a health plan).

111. Ann Black, *Communication Vital to Success of New Benefit Plan Designs*, EMP. BENEFIT NEWS, May 1, 2005 (stating that benefits communication should be conducted continuously over an extended period of time and should be monitored frequently for results).

112. *See id.* (discussing how a targeted message will guide employees in making health care decisions).

113. *See* Hirschman, *supra* note 77 (explaining that managing depression is possible when such an approach is used).

114. Maria A. Morrison, *Changing Perceptions of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation*, 45 S.D. L. REV. 8, 8 (2000).

115. *See id.* at 8–9 (resulting in what is now called mental health parity).

116. *See id.* at 9 (offering a statistic from a study that found seventy-one percent of the general population believed mental illness was the result of emotional weakness).

that is common among those who may otherwise benefit from treatment but resist it to avoid the attaching stigma.[117]

In 1996 Senator Pete Domenici demanded equal treatment by introducing the Mental Health Parity Act (MHPA),[118] a bill "to provide health plan protections for individuals with a mental illness."[119] The MHPA insists that plans offering medical and surgical benefits[120] as well as mental health benefits[121] may not include aggregate lifetime limits on mental health benefits if such limits are not also placed on the medical and surgical benefits.[122] If limits do exist they must be applied at the same level to medical, surgical, and mental health benefits.[123] At first glance the MHPA appears to be strong legislation, but beyond the aggregate annual and lifetime limits requirement, it allows several loopholes for restricting mental health benefits.[124] In fact, under the MHPA it is acceptable if

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117. *See id.* (citing the medical profession's own unwillingness to seek mental health treatment due to stigmatization).

118. See Mental Health Parity Act, 29 U.S.C.A. § 1185a (West 2005) for the law regarding parity in application of certain limits to mental health benefits.

119. *See* Mental Health Parity Act of 1996, S. 2031, 104th Cong. (1996) (enacted) (referring to the purpose of the bill).

120. *See* Mental Health Parity Act, 29 U.S.C.A. § 1185a(e)(3) (West 2005) (defining medical and surgical benefits as "benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health benefits").

121. *See id.* at § 1185a(e)(4) (defining mental health benefits as "benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency").

122. *See id.* at § 1185a (stating that "[i]f the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits").

123. *See id.* The Act states that

> [i]f the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable lifetime limit"), the plan or coverage shall either (i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or (ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit. *Id.*

124. *See* Bruce S. Harrison & W. Robert Donovan, Jr., *The Growing Demand for Equal Treatment of Mental and Physical Illnesses in Insurance Policies, and What It Means to Employers*, 2 BENDER'S LAB. & EMP. BULL. 310, 311 (2002) (referring to the employer's option to refuse to provide any mental health benefits, but recognizing that this is not a realistic option for most employers because it would place them at a disadvantage in the competitive labor market).

mental health benefits are not offered in the health plan.[125] Additionally, under the MHPA, the provider has the ultimate discretion to determine which treatments qualify as a mental health service,[126] specifically exclude treatment for substance abuse or chemical dependency,[127] provide an exemption for small employers,[128] or completely exempt a health plan if it can show a cost increase of one percent.[129] Unfortunately, the law effectively "provides a number of ways that mental health benefits may be limited more than physical health benefits."[130]

The Wellstone Act seeks to close certain loopholes that exist in the MHPA and compel insurance providers to end discrimination against individuals seeking mental health treatment.[131] Insurance and business groups argue that passage of such a bill would cause a marked increase in health care costs.[132] The Congressional Budget Office conducted a study of the cost effects of Mental Health Equitable Treatment Act proposed in 2001 and found that the direct costs of the Act would result in an increase of less-than-one percent.[133] This increase is acceptable even under the less-stringent MHPA standards which allow an exemption to employers who can prove increases of actual claims of more than one percent.[134] In

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125. *See* Mental Health Parity Act, 29 U.S.C.A. § 1185a(b)(1) (West 2005) (stating that "[n]othing in this section shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits").

126. *See id.* at § 1185a(e)(4) (defining mental health services as that which is defined under the terms of the plan).

127. *See id.* (excluding benefits with respect to treatment for "substance abuse or chemical dependency").

128. *See id.* at § 1185a(c)(1)(B) (exempting from coverage any small employer which is defined as those employers with no more than fifty employees).

129. *See id.* at § 1185a(c)(2). The Act states that

> [t]his section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least one percent. *Id.*

130. Harrison & Donovan, *supra* note 124, at 312 (stating that the most extreme way to limit mental health benefits is to offer none at all).

131. AM. COUNSELING ASS'N, *supra* note 28 (urging to supporters of mental health parity to send a suggested message to their senator or representative).

132. *See id.* (illustrating one of the large groups that continue to challenge mental health parity).

133. CONG. BUDGET OFFICE, S. 543 MENTAL HEALTH EQUITABLE TREATMENT ACT OF 2001, Aug. 22, 2001, http://www.cbo.gov/ftpdocs/30xx/doc3013/s543.pdf.

134. *See* Michael J. Carroll, Comment, *The Mental Health Parity Act of 1996: Let it Sunset if Real Changes are Not Made*, 52 DRAKE L. REV. 553, 561–62 (2004) (explaining that a covered plan must first comply with requirements of the Act for six months and after six months the plan may evaluate the actual costs associated with compliance). If compli-

addition, the United States Surgeon General supports the position that parity legislation creates a minimal cost increase.[135] Still, the insurance industry maintains that the proposed changes will cause soaring health care costs.[136] Opponents of the Wellstone Act insist on citing dramatic cost increases in an apparent attempt to shift the focus away from the fact that this proposed legislation seeks to eliminate discrimination against insured individuals who seek equitable mental health treatment. The concerns over perceived cost increases have been dispelled by the Surgeon General and the Congressional Budget Office, but the ultimate goal of eradicating discrimination against those with mental health disorders will not be realized until the Wellstone Act is passed by Congress. The enacted version of the MHPA is much different from the original proposal.[137] The late Senator Paul Wellstone co-sponsored the MHPA and the more recent Wellstone Act.[138] The Senate originally passed this bill in 2001 as the Mental Health Equitable Treatment Act of 2001.[139] It included comprehensive legislation which prohibited discriminatory practices such as placing limits on days of treatment and number of doctor visits.[140] In addition, the Wellstone Act did not allow an exemption for increased costs and did not contain a "sunset date."[141] Despite its success in the Senate, the bill failed in the House in 2001 where the MHPA was given a one-year extension and continues to receive such extensions each year.[142]

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ance results in a one percent increase the plan may notify its participants and the appropriate federal agency that it intends to claim the exemption. *Id.*

135. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 5, at 428 (introducing managed care limits and the costs of implementing parity laws, and also showing that parity results in an increase of less than one percent).

136. Harrison & Donovan, *supra* note 124, at 310.

137. *See* Carroll, *supra* note 134, at 555–56 (explaining Senator Domenici's description of unequal treatment during the floor debates, the Senator's personal connection with mental illness, the ensuing outcry over the perceived increase in costs resulting from the proposed legislation, and the ultimate delivery of a "watered-down" version of the original bill).

138. *See generally* Paul Wellstone Mental Health Equitable Treatment Act, H.R. 1402, 109th Cong. (2005) (enacted) (seeking to provide truly equal coverage for mental health benefits).

139. *See* Mental Health Equitable Treatment Act of 2001, S. 543, 107th Cong. (2001) (enacted). This Act was later renamed the Paul Wellstone Mental Health Equitable Treatment Act of 2005 in honor and memory of Senator Wellstone.

140. *See* AM. COUNSELING ASS'N, *supra* note 28 (contrasting the current law that allows these limitations).

141. *See id.* (explaining that the proposed law would allow for permanent benefits).

142. *See id.* (substituting extensions of the sunset date of the MHPA in lieu of permanent applicability of more comprehensive legislation).

Americans are sending a clear message to Congress; they support mental health parity even if it requires absorption of some of the costs.[143] Eighty-three percent of Americans surveyed consider limits on mental health coverage unfair and seventy-nine percent support mental health parity even if it causes an increase in their insurance premiums.[144] The American sentiment combined with the Congressional Budget Office's prediction of a less-than-one percent increase in costs shoots holes in health insurance companies' fiscally-based objections to the legislation.[145]

As the American voice against mental health discrimination grows, the American employer has a responsibility to respond to the concern with proactive plans to assist employees affected by mental health disorders. Private health insurance generally restricts coverage for mental health as compared to general medical coverage for traditionally physical disorders.[146] In its mental health study, the United States Surgeon General found that private health insurance providers either refused to offer coverage for mental health benefits or imposed various financial restrictions such as higher copayments or lower lifetime limits on care.[147] This result negates the goal of health insurance, which is to protect the insured from a catastrophic financial loss.[148] In addition, four of the ten leading causes of disability in the United States are mental disorders.[149] In 1990, the indirect costs of mental illness totaled seventy-nine billion dollars, and sixty-three billion dollars of those costs represented loss of productivity because of a mental illness.[150] For this reason, employers should focus on supporting mental health parity to help American workers get the health

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143. Press Release, Nat'l Mental Health Ass'n, Americans to Congress: Pass Mental Health Parity Legislation (Oct. 2, 2002), http://www.nmha.org/newsroom/system/news.vw.cfm?do=VW&rid=461 (citing a study in 2002 conducted by Opinion Research Corporation which found that Americans are willing to pay more in insurance premiums).

144. *See id.* (reporting the results of a survey conducted by the Opinion Research Corporation in 2002). The results indicate that a majority of survey respondents supported parity legislation notwithstanding increases in health insurance premiums. *Id.*

145. *See* CONG. BUDGET OFFICE, *supra* note 133 (explaining that if mental health parity were enacted, premiums for group health coverage would increase by 0.9%).

146. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 5, at 418 (pointing out the separate and lower lifetime limits as well as separate and higher deductibles).

147. *See id.* (citing that the higher out-of-pocket expense resulted in catastrophic financial losses or transfer of care to public sector providers).

148. *See id.* (explaining that those who have a severe illness face financial ruin due to inadequate protection from their insurance provider).

149. Harrison & Donovan, *supra* note 124, at 312 (listing "major depression, bipolar disorder, schizophrenia and obsessive-compulsive disorder" as the four causes of disability).

150. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 5, at 411 (citing an additional $12 billion due to premature death and $4 billion due to productivity lost due to incarceration).

care services they need while simultaneously serving the employers' need to remain financially solvent.[151]

In addition to the national effort, mental health parity has gathered support from the individual states as well. The loopholes in the MHPA have spurred several states to enact more comprehensive parity laws.[152] More than thirty states passed laws between 1997 and 2001 mandating some form of mental health coverage.[153] As of 2005, thirty-four states have enacted laws related to mental health parity.[154] Some laws are more comprehensive than others, but more important is that the issue of mental health parity is garnering more attention than before.[155] As an example, the Surgeon General's support of mental health parity[156] and the National Mental Health Association's goal to dispel the myths regarding the "dangers" of mental health parity[157] bring this issue to the forefront of American policy.

Employees suffering from mental health impairments have sought protection under Title I of the ADA[158] by initiating claims against employers who provide mental health benefits at a lower level than physical health benefits.[159] But, the courts have not been supportive of employee's claims.[160] In *EEOC v. Staten Island Savings Bank*,[161] (hereinafter *Staten Island)* the plaintiff was "unable to work because of a panic disorder with

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151. *See* NAT'L MENTAL HEALTH ASS'N, GETTING PAST THE MYTHS OF PARITY, http://www.nmha.org/state/parity/paritymyths.pdf (last visited Oct. 26, 2006) (responding to myth number two that parity will be harmful). The NMHA cites that untreated illnesses cost $113 billion each year. *Id.*

152. Carroll, *supra* note 134, at 563.

153. *See id.* (speculating that the MHPA may have caused the states' legislative reaction because of the unequal mental health benefits).

154. NAT'L MENTAL HEALTH ASS'N, IT IS TIME TO PASS COMPREHENSIVE HEALTH INSURANCE PARITY!, http://www.nmha.org/state/parity/index.cfm (last visited Oct. 26, 2006).

155. *See* NAT'L MENTAL HEALTH ASS'N, WHAT STATES HAVE DONE TO ENSURE HEALTH INSURANCE PARITY?, http://www.nmha.org/state/parity/state_parity.pdf (last visited Oct. 26, 2006) (listing states in order of best parity laws to no parity laws). Connecticut, Maryland, Minnesota, Vermont and Oregon are the states with the best parity laws and Idaho and Wyoming still have no parity laws. *Id.*

156. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 5, at 428 (compiling a comprehensive report of mental health in the United States).

157. *See* NAT'L MENTAL HEALTH ASS'N, *supra* note 151 (listing ten myths, including the myth that parity is too expensive and the myth that parity will allow misuse of the system, and answering each myth with what it calls "the reality").

158. *See* Americans with Disabilities Act, 42 U.S.C.A. § 12112 (West 2005) (stating that "[n]o covered entity shall discriminate against a qualified individual with a disability").

159. Harrison & Donovan, *supra* note 124, at 310.

160. *See id.* at 312 (citing several cases in a footnote where the courts felt that different benefit levels for mental versus physical disabilities does not violate the ADA).

obsessive-compulsive symptoms."[162] Due to his disability, the employee qualified for the company's disability benefit.[163] Generally benefits under the plan were available until the normal social security retirement age; however, benefits for disability due to a mental or emotional condition were treated far differently and limited to coverage for a meager two years from the inception of the disability.[164] The United States Court of Appeals for the Second Circuit affirmed the lower court's decision and dismissed the case for failure to state a claim.[165] Stating that the ADA supported its decision, the court held:

> The plans at issue do employ facially discriminatory classifications that target the mentally and emotionally disabled for more limited coverage on the basis of their particular form of disability. On the other hand, the complainants here enjoyed access to exactly the same benefit plans as did their physically disabled and non-disabled coworkers. The mentally and emotionally disabled were not required to pay more for their coverage or slated to receive a different plan. They were given access to the same fringe benefit plan as their coworkers and, in that sense, enjoyed equal "compensation, ... terms, conditions, and privileges of employment," as required by § 102 of the ADA. Viewed through this lens, they were not discriminated against at all. For these reasons, we cannot determine using only the plain language of the ADA whether the conduct of the complainants' employers was "discriminatory in the usual sense of the term."[166]

The EEOC in *Staten Island* urged the court to interpret Title I of the ADA as requiring a finding of discrimination based on the employer's unequal treatment of persons with mental rather than physical disabilities.[167] However, the court denied the interpretation for fear that it "would require far-reaching changes in the way the insurance industry

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161. *See generally* EEOC v. Staten Island Sav. Bank, 207 F.3d 144 (2d Cir. 2000) (agreeing with the results of the district court which found that varying levels of benefits for different disabilities in a disability claim does not violate Title I of the ADA).

162. *Id.* at 146 (stating the complainant's condition that formed the basis of the suit).

163. *Id.* (acknowledging that the complainant's employer approved the complainant's eligibility under an SISB plan).

164. *Id.* (describing the benefits available under the SISB plan and noting the differences between benefits for "disabilities" and "mental or emotional conditions").

165. *See id.* at 148 (agreeing with the results of the district court which found that varying levels of benefits for different disabilities in a disability claim does not violate Title I of the ADA).

166. *Staten Island Sav. Bank*, 207 F.3d at 149.

167. *Id.* at 151.

does business."[168] The decision in *Staten Island* also provides that the legislative history clearly supports the argument that an employer may limit certain benefits so long as the employer ensures that all persons with disabilities enjoy equal access to the insurance benefit provided by the employer.[169]

The Fourth Circuit also relied on this line of reasoning in *Lewis v. KMart*[170] and stated: "federal disability statutes are not designed to ensure that persons with one type of disability are treated the same as persons with another type of disability."[171] In a nutshell, discrimination does not exist if individuals with mental disabilities and all other employees have identical access to disability benefits.[172] Having identical access to the benefit plan is of little comfort if courts will not challenge the status quo to force the insurance industry to provide equitable coverage regardless of the type of disability. The facially discriminatory practices of insurance providers with regard to disability benefits are an additional attack on the mentally disabled since they are often not provided with evenhanded treatment options in the first place. The mentally ill employee is afforded second class status with regard to treatment options and again with regard to disability coverage.

Employers may rationalize that affirmative steps toward mental health parity are not required because Congress has not mandated it through legislative action[173] and courts have declined to enforce it through recent decisions regarding ADA claims.[174] But the writing is on the wall and the drive for true mental health parity is not weakening. The government is

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168. *See id.* at 149 (stating that if this was the goal of the ADA, Congress would have provided a clear legislative command).

169. *Id.* (citing H.R. REP. NO. 101–48 (III), at 38 (1990)).

170. Lewis v. KMart Corp., 180 F.3d 166 (4th Cir. 1999).

171. *Id.* at 171–72 (contrasting the Age Discrimination in Employment Act where all persons over the age of forty must be treated equitably in relation to all other persons, while the ADA and the Rehabilitation Act permit preferential treatment between disabilities).

172. *See generally* Harrison & Donovan, *supra* note 124, at 312 (referring to instances where employees unsuccessfully sued their employers under Title I of the ADA when disability insurance policies provided fewer benefits for a mental health disability as compared to a physical disability).

173. *See* Mental Health Parity Act, 29 U.S.C.A. § 1185a (West 2005) (noting that Congress merely extended the sunset date on the Mental Health Parity Act of 1996 in lieu of passing more comprehensive legislation like the Paul Wellstone Mental Health Equitable Treatment Act).

174. *See* EEOC v. Staten Island Sav. Bank, 207 F.3d 144, 146 (2d Cir. 2000) (holding that Title I of the ADA does not prevent employers from offering different benefits for mental and physical disabilities); Lewis v. KMart Corp., 180 F.3d 166, 171–72 (4th Cir. 1999) (holding that Title I of the ADA does not require the employer to provide equal benefits for mental and physical disabilities).

taking some action to enforce compliance with health care regulation. In fact, the Employee Benefit Security Administration (EBSA) of the Department of Labor (DOL) audits numerous health care plans to gauge the level of compliance with health laws like the MHPA.[175] In a 2002 compliance review project, the DOL discovered that nearly fifty percent of the surveyed plans were not compliant with a provision of a major health law.[176] In response to compliance issues, the DOL provides useful tools to help employers comply with current health care laws.[177] For example, the DOL's website provides employers with tips to understand the requirements of recent health care legislation.[178]

Lacking direct and meaningful pressure from Congress and the courts, the burden rests squarely on the shoulders of employers to recognize the social data as provided in the Surgeon General's comprehensive report on mental illness[179] and analyze the productivity statistics.[180] Our American culture is traditionally less supportive of mental health conditions than physical ailments. Many times there is a feeling that a person with mental illness is "just not trying hard enough" to overcome the ailment.[181] To remedy this historical trend, employers can begin with small steps such as initiating dialogue with the employee and referring the employee to an EAP if the employer suspects a mental health condition.[182] But the real impact will come from the employer's commitment to provide employees with equal availability of treatment for mental and physical ailments. The employer should rely on its financial concerns because

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175. Kaye Pestaina, *Beyond HIPAA: DOL Steps Up Health Plan Enforcement: Employers Should Take Advantage of DOL Guidelines to Identify and Correct Gaps in Health Plan Compliance*, EMP. BENEFIT NEWS, Mar. 1, 2005, *available at* http://www.keepmedia.com/pubs/EmployeeBenefitNews/2005/03/01/759034.

176. *Id.* (citing the audited health laws as "HIPAA's portability and nondiscrimination requirements, the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act and the Women's Health and Cancer Rights Act").

177. *Id.* (listing documents available on the DOL's website intended to assist employers with compliance in its group health plans).

178. *See generally* U.S. DEP'T OF LABOR, COMPLIANCE ASSISTANCE FOR GROUP HEALTH PLANS – HIPPA AND OTHER RECENT HEALTH CARE LAWS (Oct. 2002), *available at* http://www.dol.gov/ebsa/publications/top15tips.html (providing a list of helpful tips when dealing with employee benefits laws).

179. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 5, at 3 (providing information regarding comprehensive research focused on mental health and the obstacles that impede accessibility to mental health services).

180. *See id.* at 418 (citing that the higher out-of-pocket expense resulted in catastrophic financial losses or transfer of care to public sector providers).

181. Albert, *supra* note 65 (indicating that our American culture has supported the concept of mental health inequity because such sentiment is never directed at someone suffering from cancer or heart disease).

182. Berube, *supra* note 84 (stating that most employees with depression can be effectively treated if the employer chooses to be proactive).

the costs related to lost productivity, absenteeism[183] and disability benefits[184] are enormous. Accordingly, the employer should shy away from the shallow argument that real mental health parity comes with too large a price tag.[185] Helping employees effectively deal with mental health ailments provides a benefit to the employers bottom line and in reality is just good business.

V. CONCLUSION AND PROPOSAL/CONCLUDING REMARKS

> We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community.[186]

The statement above represents the vision of the President's New Freedom Commission on Mental Health (the Commission).[187] President George W. Bush identified obstacles confronting Americans who suffer from mental illness.[188] These obstacles include the stigma associated with mental illness and discriminatory limitations attached to mental health treatment.[189] In describing these obstacles the President said,

> Stigma leads to isolation, and discourages people from seeking the treatment they need. Political leaders, health care professionals, and all Americans must understand and send this message: Mental disability is not a scandal; it is an illness. And like physical illness, it is treatable, especially when the treatment comes early.[190]

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183. FRIERSON, *supra* note 4 (indicating that direct and indirect costs related to absenteeism and lost productivity can soar to $249 billion each year).

184. Gunsauley, *supra* note 105 (asserting that absences due to disability and lost productivity are four times as costly as traditional health plan expenses).

185. CONG. BUDGET OFFICE, *supra* note 133 (asserting that the direct costs of the MHPA would result in an increase of only 0.9%).

186. PRESIDENT'S NEW FREEDOM COMM'N ON MENTAL HEALTH, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA, EXECUTIVE SUMMARY (July 22, 2003), http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/ExecSummary.pdf [hereinafter COMM'N ON MENTAL HEALTH].

187. PRESIDENT'S NEW FREEDOM COMM'N ON MENTAL HEALTH, FINAL REPORT TO THE PRESIDENT NOW AVAILABLE, http://www.mentalhealthcommission.gov (last visited Oct. 26, 2006).

188. COMM'N ON MENTAL HEALTH, *supra* note 186.

189. *See id.* (declaring that The President's New Freedom Commission on Mental Health was launched to address the current problems and obstacles faced by Americans).

190. PRESIDENT'S NEW FREEDOM COMM'N ON MENTAL HEALTH, REMARKS BY PRESIDENT BUSH IN ANNOUNCING THE NEW FREEDOM COMMISSION ON MENTAL HEALTH (April 2002), http://www.mentalhealthcommission.gov/address.html.

The President extended a challenge to all Americans to understand mental illness and assist in its treatment. The relevance to the nation is exemplified by the fact that the Commission found that no community or workplace is untouched by mental illness.[191] As such, the employer is in a perfect position to assist in bringing down the barriers facing the mentally disabled. Employers can play a vital role in addressing the stigma of mental illness. Employers can educate the workforce by providing a first line of defense through an EAP to assist with confronting the stigma.[192] Additionally, support for the Wellstone Act and achievement of true mental health parity that is not subject to sunset dates and exemptions will not only aid in destroying stigma, but will also provide the necessary treatment for individuals suffering from a mental health disorder.[193]

Even with the President's expressed support for mental health equity, the danger of continued inequity threatens the livelihood of employees and employers. Obviously the employee is threatened by the prospect of dealing with a multitude of responsibilities that can lead to compromised mental health and ultimately mental illness. This in turn affects the employer who will experience losses in productivity and increased absenteeism. Ultimately it affects the bottom line of both the employee's and employer's health and well being.

Congress, with its approval of the MHPA, is hardly compelling employers to do anything radical and the courts are often ratifying policies of discrimination. The White House has not pressed the issue to the extent that comprehensive legislation, such as the Wellstone Act, will survive the challenges present in Congress.[194] One can hope that help from employers will come as a result of concern for the bottom line. Perhaps the statistics regarding absenteeism, loss of productivity and an overall increase in costs will persuade employers to seriously consider mental health disorders and their implication on the employer's cost of doing

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191. *See* COMM'N ON MENTAL HEALTH, *supra* note 186 (stating that mental illness can happen to any person and at any stage of life).

192. *See* Carolyn Hirschman, *Firm Ground: EAP Training for HR and Managers Improves Supervisor-Employee Communication and Helps Organization Avoid Legal Quagmires*, 18 EMP. BENEFIT NEWS 11, Sept. 1, 2004 (explaining that EAP's have become a mainstay in benefit offerings and assist employees in dealing with a variety of emotional, financial and legal problems).

193. *See generally* Paul Wellstone Mental Health Equitable Treatment Act, H.R. 1402, 109th Cong. (2005) (enacted) (declaring the goal of this Act to be the provision of equal coverage of mental health benefits). Such equal coverage removes the second-class status felt by those experiencing mental illness. *Id.*

194. AM. COUNSELING ASS'N, *supra* note 28 (stating that the House members remain opposed to the legislation and the White House has not done enough to cause a shift in the mindset of House leaders).

business. Employers must be convinced to do the right thing by employing novel approaches to the provision of employee benefits and services.

Employers not willing to take the plunge and advocate for mental health parity may elect instead to take baby steps toward creating a working environment conducive to improved mental health. A look at the Fortune 100 Best Companies to Work For (the Fortune List)[195] shows that some companies understand the concept of creating a great place to work. The Fortune List focuses on employee oriented companies that demonstrate a dedication to their employees. This overall dedication creates a working environment that comforts employees dealing with mental health issues.

The Fortune List includes companies from all over the country and engaged in all manner of business.[196] The wonderful thing about the employers included on the Fortune List is that what makes them the best in their employees' minds is not solely about compensation.[197] The "outside-of-the box" benefits and services offered by these companies translate into employees who rank their employer with high marks in terms of job satisfaction, camaraderie and management attitudes.[198] As such, the employers on this list, with their evident employee focus, provide an overall better working environment for their employees. This is done by providing perks such as yoga instruction to aid in "good mental practice,"[199] child care centers,[200] dry cleaning,[201] on-site concierge ser-

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195. Robert Levering et al., *The 100 Best Companies to Work For*, FORTUNE, Jan. 12, 2004, at 56.

196. *See id.* (including at number one J.M. Smucker based out Orrville, Ohio; number six Adobe Systems out of San Jose, California; and number sixty-four General Mills with headquarters in Minneapolis, Minnesota).

197. *See id.* (showing Genetech at number fifteen on the list). This company rose from number eighty on the list the prior year and offers access to a hair salon and dry cleaning services. *Id.*

198. *See* Robert Levering & Milton Moskowitz, *How We Pick the 100 Best*, FORTUNE, Jan. 24, 2005, at 97 (explaining the process for evaluating the companies and the employee survey which counts for two-thirds of the total score).

199. *See, e.g.*, Levering et al., *supra* note 195 (listing the Container Store at number three and describing how a Container Store's Informant-Systems Director provides free weekly yoga classes to colleagues as a company perk). Information pertaining to the Container Store is available at www.containerstore.com. *Id.*

200. *See id.* (describing the options provided to employees by the SAS Institute that include a choice of cafeterias, child-care centers and on-site fitness centers). The SAS institute placed eighth on "The 100 Best Companies to Work For." *Id.* Information about the employer is available at www.sas.com. *Id.*

201. *See id.* (listing number fifteen, Genetech; number thirty-two Valero; number sixty-one Nvidia).

vice,[202] flexible scheduling,[203] staff nurses who provide advice about elder care and pregnancy,[204] and seminars on managing stress.[205] In fact, some of the perks offered by these employers are listed by the Substance Abuse and Mental Health Service Administration as alternative methods for achieving good mental health.[206] Even small businesses that do not enjoy the same level of financial resources as businesses on the Fortune List can adopt similar approaches to raise employee satisfaction. The point to take away from this is that creating an environment where employees are enthusiastic enough to respond to lengthy surveys and rate their employer as "the best" can certainly translate into an environment that addresses the challenge of mental illness.

The impact of mental illness on the workforce is undeniable. The Surgeon General's report demonstrates that twenty percent of Americans face the challenge of living with a mental disorder.[207] This exacts a heavy toll and represents a huge bill that employers must pay in direct and indirect costs for employees with mental illness.[208] It is time for employers to address the issue in a meaningful way and resist the urge to cite concern for increased health care costs as a reason not to support mental health parity. The Congressional Budget Office already addressed this cost issue and the actual impact is minimal.[209] Employers may begin by emulating the working environment created by the employers listed on the Fortune

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202. *See id.* (listing services, such as shopping and errand running, offered to employees under the company's health-care group). Bronson Healthcare placed twenty-first on "The 100 Best Companies to Work For." Information regarding Bronson Healthcare is available at www.bronsonhealth.com. *Id.*

203. *See id.* (listing MITRE as member thirty–eight). MITRE allows employees to create their own forty–hour work week. *Id.*

204. *See* Levering et al., *supra* note 195 (suggesting that the IT firm maintains healthy employees by providing services such as on-site clinics and staff nurses). SRA International ranked fortieth on the list and company's website is available at www.sra.com. *Id.*

205. *See id.* (mentioning benefits, including on-site gyms, career mentoring, and paid maternity leave provided to Goldman Sachs employees). Goldman Sachs placed forty-first on the "The 100 Best Companies to Work For." *Id.* Information on Goldman Sachs can be found at www.gs.com. *Id.*

206. *See generally Alternative Approaches to Mental Health Care*, SAMHSA's Nat'l Mental Health Info. Ctr., Apr. 2003, *available at* http://www.mentalhealth.samhsa.gov/publications/allpubs/ken98-0044/default.asp (providing a list of alternative approaches to mental health care). The list includes self-help groups, yoga/mediation exercises, and diet and nutrition advice. *Id.*

207. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 5, at 15 (disclosing background information pertaining to mental health issues). The background information is helpful to better comprehend topics subsequently addressed throughout the report. *Id.*

208. *See id.* at 411 (recognizing that the enormous emotional and financial costs borne by the individual are accompanied by significant costs to be paid by the Nation's employers).

209. CONG. BUDGET OFFICE, *supra* note 133.

List. Employers do not have to wait until Congress finally passes the Wellstone Act. An action plan must be implemented today to outline steps employers will take in selecting health insurance coverage that addresses the needs of employees like those caring for children and parents, suffering from a psychological disorder, or struggling with substance abuse. Equality in treatment of mental health illness is the only real solution.